

Patient #4

Section #3

Follow-up reports 10/4/07 – 5/28/08

Insert of Sleep Apnea or Snoring Appliance:

Date 10/4/07
Date of Birth 7/11/56

This section should be completed by the patient or legal guardian

Patient name [REDACTED]

Guardian or parent name, if patient is a minor: _____

Have there been any medical changes since the initial appointment? Yes ___ No ___

If yes, note them here (medication changes, illnesses, accidents, treatments, medical tests, etc.)

[REDACTED]
Patient signature (parent or guardian if patient a minor)

10/4/07
date

To be completed by the office staff:

Staff name: [REDACTED]

- Patient consent signed and in record? Yes No ___
- Appliance inserted? Yes No ___
- Appliance is comfortable to patient? Yes No ___
- Patient instructed how to use the appliance? Yes No ___
- Explained how / when to use bite tabs? Yes No ___
- Patient given appliance written instructions? Yes No ___
- Patient understands how & when to use appliance? Yes No ___
- Instructions about follow-ups have been discussed? Yes No ___
- Patient practiced placing/removing appliance? Yes No ___

Inserted for: ___ Snoring
___ OSA
___ UARS
___ Other:

Treatment provided today:

- ___ Insert TAP - T
- ___ Insert TAP - 3
- ___ Insert Somnosed
- Insert PM positioner
- ___ Insert SUAD
- ___ Insert EMA
- ___ Insert TAP-II
- ___ Insert Silent Night
- ___ Other appliance _____
- ___ Home wear & care instructions (verbal)

Maxillary retention: good

Mandibular retention: good

Adjustments made today:

- mild intaglio, over mandibular anterior (to ↓ some pressure)

0 turns for 1 week then 1-2 turns 2nd week stressed bite tabs made anterior deprogrammer stent but he says he will likely not wear this during the day - he is "not concerned" of his bite

Disposition: Follow-up 2 weeks

[Signature]
(Dr's. signature)

10/4/07
(date)

Oral hygiene issues discussed with patient: flossing, care of appliance

Treatment performed today:

Follow-up

Adjust appliance: #7, 8, 9, 10 mirror reflect made

Discuss Home monitoring

Check out Home monitoring device

Review results of HMD with patient Results: _____

Other treatment: _____

Notes: states he is sleeping well with the splint.

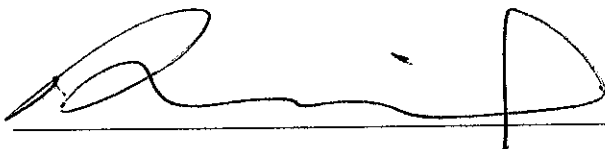
No increased mobility
Re-bite tabs and importance -
says he uses them

Treatment plan:

1 turn per week as long
as is comfortable, if
teeth continue to be sore
or loosen. Come in sooner

Return appointment: 6 weeks

Dr. Signature: _____



Date: _____

10/18/07

Check-up of Sleep Apnea or Snoring Appliance:

Date: 11/19/07
 DOB: 7/11/56
 JLM MKK RJM

This section should be completed by the patient or legal guardian

Patient name [REDACTED]
 Guardian or parent name, if patient is a minor: _____

Have there been any Medical changes since the initial appointment? Yes ___ No X
(medication changes, illnesses, accidents, treatments, etc.)

Any Dental treatment since your last visit Yes ___ No X
(check-up, fillings, cleaning, crowns, etc.)

How many nights per week do you wear the appliance? 0 1-2 3-4 5-6 7
 How many hours per night do you wear the appliance? 0 1-3 4-6 6-8 9 or more

Do you still snore? Yes ___ No SOME / BETTER

Do you feel it has been beneficial for your sleep? Yes X No ___

Is the appliance comfortable? Yes X No ___

Do you feel more refreshed during the day? Yes ___ No X

Do you have more energy? Yes ___ No X

Does your "bite" feel normal (the way your teeth come together)? Yes X No ___

Do you have pain in your jaws or TMJs (jaw joints)? Yes X No ___

Please rate how likely you are to doze off or fall asleep in the following situations. Use the scale to rate how likely you are to fall asleep with each particular activity. Even if you have not been in that situation lately estimate how it would affect you.

0 - would never doze
 1 - slight chance of dozing
 2 - moderate chance of dozing
 3 - high chance of dozing

Sitting and reading 1
 Watching TV 1
 Sitting inactive in a public place (theater, meeting, library) 0
 As a passenger in a car for an hour without a break 1
 Lying down to rest in the afternoon 2
 Sitting and talking to someone 0
 Sitting quietly after lunch (without alcohol) 2
 In a car, while stopped for a few minutes in traffic 0

TOTAL 7

[REDACTED] patient signature (parent or guardian if patient a minor) 11-19-07 date

To be completed by the office staff:

Staff Name [REDACTED]

Problems:

<input checked="" type="checkbox"/> Tight	Appliance adjusted to comfort?	Yes <u>/</u> No ___
<input checked="" type="checkbox"/> Too loose	Re-instructed on use of the appliance?	Yes <u>/</u> No ___
<input checked="" type="checkbox"/> Occlusion	Explain how / when to use bite tabs?	Yes <u>/</u> No ___
<input checked="" type="checkbox"/> Gagging	Re-home care instructions?	Yes <u>/</u> No ___
<input checked="" type="checkbox"/> Teeth sore	Re: how & when to use appliance?	Yes <u>/</u> No ___
<input checked="" type="checkbox"/> TMJ pain <u>TMJ sore chewing</u>	Follow-ups have been discussed?	Yes <u>/</u> No ___
<input checked="" type="checkbox"/> Excessive protrusion		
<input checked="" type="checkbox"/> Excessive retrusion		

BP: 120/67

Adjustments made by patient: (turns, elastic bands, spacers, etc.) 5 turns

MI occlusion (shimstock):

1	2	3	4	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	9	10	11	12	13	14	15	16
32	31	30	29	<u>28</u>	<u>27</u>	<u>26</u>	<u>25</u>	<u>24</u>	<u>23</u>	<u>22</u>	<u>21</u>	<u>20</u>	19	18	17

Facets that don't match:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
<u>1</u>															
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Oral tissues: normal

Oral hygiene issues discussed with patient: OH much better (today), no BOP

Treatment performed today:

Follow-up

Adjust appliance: #9 - mild adjustment (right coming off)

Discuss Home monitoring

Check out Home monitoring device

Review results of HMD with patient Results: _____

Other treatment: _____

Notes:

use moist heat twice daily
over R TMJ. Monitor diet
(brown/bagels/nuts (chewy foods))
for 2-4 weeks
wear every night

Treatment plan:

0 turns for 2 weeks, then
if comfortable, 1 turn per
week for 4-6 weeks.

Return appointment: 2 months

Dr. Signature: 

Date: 12/19/07

Oral hygiene issues discussed with patient: FLOSS & continue cleanings

Treatment performed today:

Follow-up

Adjust appliance: _____

Discuss Home monitoring

Check out Home monitoring device

Review results of HMD with patient Results: _____

Other treatment: _____

Notes: Re-bite tabs and bite changing,
says it feels the same to him,
but will continue/increase
bite tabs and clench for 5-10 seconds
few times a day. CT scans
reviewed with pt.

Treatment plan: Refer to [REDACTED]
lab ([REDACTED]) for titration
study. Info sent to lab & Dr.

Return appointment: 1 month after titration study

Dr. Signature: _____

Date: 1/18/06

Oral hygiene issues discussed with patient: had deep cleaning few weeks ago
(w2-3 wks)

Treatment performed today:

Follow-up

Adjust appliance: _____

Discuss Home monitoring

Check out Home monitoring device

Review results of HMD with patient Results: _____

Other treatment: _____

Notes: stay at most recent level.

Discussed bite issues, bite tabs, perio condition, wear & care of splint, tooth loosening or bleeding gums.

- No change in mobility

Treatment plan: Continue night wear
return ASAP if bite changes

~~Follow~~ follow more closely due
to bite & perio issues

Return appointment: 3 months

Dr. Signature: 

Date: 5/25/08